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10.000 Administration

10.100 Preface

This chapter presents information about this manual. It introduces and describes the Children's Rehabilitative Services (CRS) Program, its financing, organization, and administration in the State of Arizona. It also includes the interfaces between the CRS Program and other state and federal agencies and organizations.

10.101 How to Use the Children's Rehabilitative Services (CRS) Manual

This manual contains the policies and procedures necessary for the operation of Arizona Children's Rehabilitative Services (CRS). These policies and procedures are established by the Arizona Department of Health Services (ADHS)/Office for Children with Special Health Care Needs (OCSHCN/Children's Rehabilitative Services Administration (CRSA) to implement laws and regulations, including pertinent provisions of the Arizona Revised Statutes, Federal Government Regulations, the Administrative Manual of the Arizona Department of Health Services, and such rules, regulations and procedures, as may be established by the Director of the Arizona Department of Health Services.

The chapters in this manual are divided into Sections. Chapters are numbered serially in Arabic numerals. Sections are subsets of chapters numbered serially in Arabic numerals preceded by a decimal. As an example:

10.000 - identifies Chapter as "10"

10.100 - identifies Section as "100"

10.102 Development and Revision of Policies and Procedures

Where there is a conflict between rule and policy, the rule takes precedence. CRSA rules are contained in A.A.C. R9-7-101 to R9-7-705.

All CRS policies and subsequent revisions are to be approved by the CRSA. Policies will be prepared, reviewed, and revised in consultation with the CRSA Medical Director, Regional Medical Directors and Administrators. Parent Action Council members in each region will also be invited to provide input and comments to proposed policies or revisions. The implementation of ADHS/CRS policies shall be coordinated among the Regional Contractors and others, as applicable, to ensure operating consistency throughout the CRS Program. Policies will be reviewed at least annually. Based on the policy reviews, necessary policy revisions will be made in accordance with the above procedures.

10.103 Dissemination of New Policies and Procedures

Upon the development or revision of a policy, notification will be made to all appropriate State agencies, Regional Contractor sites, and regional Parent Action Councils.

10.104 Acronyms

“AAP” The American Academy of Pediatrics.

“ADA” The Americans with Disabilities Act Public Law 101-336 enacted July 26, 1990.

“ADE” The Arizona Department of Education

“ADES” The Arizona Department of Economic Security

“ADHS” The Arizona Department of Health Services, a State agency as defined in A.R.S. Title 36, Chapter 1. Pursuant to A.R.S. Title 36, Chapter 4

“AHCCCS” The Arizona Health Care Cost Containment System, a State agency, as described in A.R.S. Title 36, Chapter 29, which is designated as Arizona's Medicaid program.

“AHCCCSA” The Arizona Health Care Cost Containment System Administration.

“ALTCS” The Arizona Long Term Care System, a program in AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by ARS 36-2931 et. seq.

“AMPM” The *AHCCCS Medical Policy Manual*.

“A.R.S.” Arizona Revised Statutes.

“AAC” Arizona Administrative Code: the state regulations established pursuant to relevant statutes. Relevant sections of the AAC are referred to throughout this document as “ADHS Rules”.

“BIA” The Bureau of Indian Affairs.

“CDT” Current Dental Terminology.

“CMS” The Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

“COBRA” The Consolidated Omnibus Budget Reconciliation Act.

“CY” Contract year, corresponds to state fiscal year (July 1 through June 30).

“CAP” Corrective action plan.

“CPM” Clinical Performance Measure.

“CPT” Current Procedural Terminology.

“CRS” Children's Rehabilitative Services.

“CRSA” Children's Rehabilitative Services Administration.

“CYE” Contract Year Ended.

“DD” Developmental Disability/Developmental Delay.

“DES” The Arizona Department of Economic Security.

“DES/CMDP” The Comprehensive Medical and Dental Program in the Department of Economic Security, Division of Children, Youth and Families, through which the State provides health care to foster children.

“DES/DDD” The Division of Developmental Disabilities in the Department of Economic Security.

“DUA” Data Use Agreement.

“DME” Durable medical equipment.

“EI” Early Intervention.

“HCFA” Health Care Financing Administration.

“FCC” Family centered care.

“FFP” Federal financial participation.

“HIPAA” Health Information Portability and Accountability.

“ICD-9” International Classification of Diseases-9th revision.

“I.D.E.A.” Individuals with Disabilities Education Act.

“LEA” Local Education Agency.

“LEP” Limited English proficiency.

"I.E.P." Individualized Education Plan.

"I.F.S.P." Individualized Family Service Plan.

"ILC" Independent Living Center.

"JCAHO" The Joint Commission on the Accreditation of Healthcare Organizations.

"MED" Medical expense deduction.

"MM" Medical Management.

"NCQA" National Committee for Quality Assurance.

"OCR" Office of Civil Rights.

"PAC" Parent Action Council.

"PIP" Performance Improvement Project.

"PHI" Protected Health Information.

"PCP" Primary Care Provider.

"PA" Prior Authorization.

"PSR" Provider Services Requisition.

"QI" Quality Improvement.

"QM" Quality Management.

"QMP" Quality Management Plan

"QOC" Quality of Care.

"SEA" State Education Agency.

"S.O.B.R.A." The Sixth Omnibus Reconciliation Act, 1986 Section 9401, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a) (10)(A)ii(IX), July 1, 1988.

"SSA" Social Security Administration.

"SSI" Supplemental Security Income.

"SPAC" State Parent Action Council.

“TBI” Traumatic Brain Injury.

“TDD” Telecommunications Device for the Deaf.

Definition of Terms

In this policy and procedure manual, unless otherwise specified:

“Abuse” Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the CRS program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the CRS program.

“Access to Care” A members' attainment of timely and appropriate health care services.

“Action” The denial or limited authorization of a requested service including:

1. The type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide a service in a timely manner, as set forth in contract; or
5. The failure of a contractor to act within the time frames specified by rule.
6. Denial of a rural CRS member's request to obtain services outside the CRS Regional Contractor's network under 42 CFR 438.52(b)(2)(ii), when the CRS Regional Contractor is the only Contractor in the rural area.

“Acute Health Care” Medically necessary ambulatory, emergency, inpatient, and follow-up health services provided in response to the various stages of disease or injury.

“Administrative Hearing” A hearing under A.R.S. Title 41, Chapter 6, Article 10 (also called State Fair Hearing).

“Advance Directives” Documents written in advance that state your choices for health care, or name someone to make choices about your care if you are unable to make decisions.

“AHCCCS Medical Policy Manual (AMPM)” The AMPM provides information regarding covered health care services for Arizona residents who are eligible for AHCCCS acute and long term care

services.

“Americans with Disabilities Act (ADA)” A Public Law 101-336 enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation.

“Appeal” A request for review of an action.

“Appeal Resolution” The written determination by the CRS Regional Contractor concerning an appeal.

“Applicant” An individual who has requested enrollment into the CRS program and for which CRS has received a written, signed, and dated application.

“Application packet” The completed documents, forms, and supplemental information necessary to process eligibility for CRS.

“Arizona Administrative Code (AAC)” State regulations established pursuant to relevant statutes. Relevant sections of the AAC are referred to throughout this document as “ADHS Rules”.

“Arizona Department of Health Services (ADHS)” A State agency as defined in A.R.S. Title 36, Chapter 1. Pursuant to A.R.S. Title 36, Chapter 4, ADHS is responsible for licensure and certification (when applicable) of health care facilities included as AHCCCS-registered providers.

“Arizona Health Care Cost Containment System (AHCCCS)” A State agency, as described in A.R.S. Title 36, Chapter 29, which is designated as Arizona's Medicaid program. AHCCCS is composed of the Administration, Contractors and other arrangements through which health care services (acute, long term care, and behavioral) are provided to members.

“Arizona Long Term Care System (ALTCS)” A program in AHCCCS that delivers long term, acute, and behavioral health care and case management services to eligible members, as authorized by ARS 36-2931 et. seq.

“Assess or Evaluate” The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to CRS Regional Contractor service delivery systems.

“Authorization request (expedited)” Under 42 CFR 438.210, means a request for which a provider indicates or a CRS Regional Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The CRS Regional Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the CRS Regional Contractor justifies a need for additional information and the delay is in the member's best interest.

“Authorization request (standard)” Under 42 CFR 438.210, means a request for which a CRS Regional Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the CRS Regional Contractor justifies a need for additional information and the delay is in the member's best interest.

“Balanced Budget Act (BBA)” of 1997, Public Law 105-33, means the Federal law that increased the attention given to performance monitoring and quality assurance in both Medicaid and the newly created State Children's Health Insurance Program.

“Business day” Monday, Tuesday, Wednesday, Thursday, or Friday unless: a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or a legal holiday falls on Saturday or Sunday and a contractor is closed for business the prior Friday or following Monday.

“Capitation” Payment of a fixed monthly payment per person in advance for which the CRS Regional Contractor provides covered services.

“Case Manager” A designated individual who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary health care.

“Children's Rehabilitative Services Administration (CRSA)” A subdivision of the ADHS, which provides regulatory oversight of the CRS Program and the contract processes as they relate to CRS Regional Contractors and the delivery of health care services.

“Children's Rehabilitative Services (CRS)” A program that provides for medical treatment, rehabilitation, and related support services to

eligible individuals who have certain medical, handicapping, or potentially handicapping conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities.

“Claim Dispute” A contested payment of a claim, denial of a claim, or imposition of a sanction.

“CLAS” Standards for culturally and linguistically appropriate services in health care assuring cultural competence in health care.

“Clean Claim” A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

“Co-Insurance” Co-Insurance (coinsurance) a cost-sharing arrangement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage or amount.

“Co-Payment” A cost-sharing arrangement in which the insured pays a specified flat amount for a specific service (such as \$10 for an office visit or \$5 for each prescription drug).

“Completion/Implementation Timeframe” The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the CRS Regional Contractor.

“Concurrent Review” The process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care.

“Contract Year (CY)” The time corresponds to state fiscal year (July 1 through June 30).

“Coordination of Care” The process that links children and youth with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

“Co-payment” An amount that the member pays directly to a provider at the time covered services are rendered.

“Corrective Action Plan (CAP)” A written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timeframes. CAPs are generally used to improve performance of the CRS Regional Contractor and/or its providers, to enhance activities and the outcomes of the activities, or to resolve a deficiency.

“Covered Services” A list of identified health medical services (refer to Chapter 40).

“CRSA Medical Director” The physician designated by CRSA to oversee the medical management portion of the CRS program. The Medical Director reports to the Office for Children with Special Health Care Needs (OCSHCN) Office Chief.

“CRS Clinic” An established clinic held at a Regional Contractor site.

“CRS Condition” A disease or disorder that qualifies for CRS coverage as identified in Chapter 30.

“CRS Credentialed Provider” The CRS Regional Contractors are credentialed as approved by hospital standards.

“CRS Eligible” An individual that has completed the CRS application process, as delineated in this CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS related services.

“CRS Member” An individual who meets CRS eligibility requirements and is enrolled in CRS.

“CRS Provider” A CRS Regional Contractor or its subcontractor who provide CRS covered services to a member.

“CRS Regional Clinic” A multi-specialty interdisciplinary facility that provides CRS services to members.

“CRS Regional Contractor” An entity contracted with CRSA under a capitation arrangement to provide CRS covered services directly or through sub-contractors to CRS members within a specific region of the state or through application of the CRS transfer policy.

“CRS Regional Medical Director” The physician appointed by the CRS Regional Contractor to make medical decisions about the medical eligibility of applicants and the medical care provided to members assigned to the CRS Regional Contractor. The Regional Medical

Director also may provide medical advice and counsel to CRSA and to the CRS Regional Contractor and interface with medical directors of other agencies and health plans on care coordination issues.

“Current Dental Terminology (CDT)” A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

“Current Procedural Terminology (CPT)” A standardized mechanism of reporting services using numeric codes as established and updated annually by the American Medical Association (AMA).

“Cultural and Linguistic Competency” Culturally and linguistically appropriate services CLS means standards to measure the ability of health care provider and health organizations to respond to the cultural and linguistic needs of the patient in health care settings.

“Culture” An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious or social group; the ability to transmit the above to succeeding generations; is dynamic in nature.

“Days” Calendar days unless otherwise specified in the text.

“DES/CMDP” The Comprehensive Medical and Dental Program in the Department of Economic Security, Division of Children, Youth and Families, through which the State provides health care to foster children. CMDP is an AHCCCS Health Plan.

“DES/DDD” The Division of Developmental Disabilities in the Department of Economic Security as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for licensure/certification of facilities for individuals with DD, providers, and the provision of services to eligible Arizona residents with DD. AHCCCS Administration contracts with DES to provide services to its members with DD.

“Deductibles” Amounts required to be paid by the insured under a health insurance contract, before benefits become payable. Usually expressed in terms of an "annual" amount.

“Diagnosis” A determination or identification of a disease or condition that is confirmed by a physician.

“Discharge Planning” A procedure where aftercare services are determined for after discharge from the inpatient facility. Required by Medicare and JCAHO for all hospital patients.

“Disease Management” An integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

1. Identifying and proactively monitoring high-risk populations
2. Assisting members and providers in adhering to identified evidence-based guidelines
3. Promoting care coordination
4. Increasing member self-management, and
5. Optimizing member safety.

“Dual Eligible” An individual who receives both Medicare and Medicaid benefits. Dually eligible people with disabilities usually receive Social Security and Medicare benefits and Supplemental Security Income (SSI) and Medicaid benefits. (The Social Security benefits are usually Disability Insurance benefits or Disabled Adult Child benefits received due to the retirement, death, or disability of a parent).

“Durable Medical Equipment (DME)” Prescribed medical equipment that can be used for an extended period of time.

“Durable Medical Equipment (DME), Customized” Equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

“Emergency Medical Condition” A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

“Emergency Medical Service” Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These conditions must be met at the time services provided or it is not covered.

“Employee” All officers and employees of the Department and of any local health department, including those who may be loaned or assigned to the Department or local health departments by another governmental or private health agency, including consultants paid on a fee basis by

the Department or a local health department.

“Encounter” A record of a health care related service, which is rendered by a provider, registered with CRS to a CRS member on the date of service, and for which a CRS contractor incurs financial liability. It is submitted by a CRS Regional Contractor to CRSA where it is processed.

“Encounter Data” Data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

“Enrolled” Any individual who has completed the application process, attended the first clinic visit, maintains medical/financial requirements, and has signed a CRS payment agreement.

“Enrollment” The process by which an eligible person becomes a member of the CRS program.

“Ex-member” An individual who is no longer enrolled in the CRS Program.

“Family-centered” Care that recognizes and respects the pivotal role of the family in the lives of children. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the child.

“Federal Financial Participation (FFP)” The Federal matching rate that the Federal government makes to the Title XIX and Title XXI programs in the state of Arizona.

“Filed” The receipt date as established by a date stamp.

“Formulary” An approved list of pharmaceuticals for dispensing for CRS Eligible conditions.

“Fraud” The intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

“Functional Status” A measure of an individual's ability to perform normal activities of life.

“Genetics” The studies of how particular traits are passed from parents to

children. Identifiable genetic information receives the same level of protection as other health care information under the HIPAA Privacy Rule.

“Grievance” An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to:

1. The quality of care or services provided; and
2. Aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Grievances do not include “action(s)” as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

“Guardianship” A person authorized under state or other law to act on behalf of the member in making health-related decisions. Examples: a parent acting on behalf of an un-emancipated minor or a parent who has petitioned for guardianship for their 18-21 year old member.

“Handicapping” Physical impairments that limit one or more major life activity such as: caring for oneself; performing manual tasks; walking; seeing; hearing; speaking; breathing; learning; and working.

“Health Care Professional” Under 42 CFR 438.2, means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed certified social worker, registered respiratory therapist and certified respiratory therapist technician.

“Health Information Portability and Accountability Act (HIPPA)” of 1996, Title II Subtitle F published by the United States Department of Health and Human Services means the administrative simplification provisions and modifications thereof, and the Administrative Simplification Compliance Act of 2001.

“Health Plan” An organization, now referred to as an Acute Care Contractor, which contracts with the AHCCCS Administration to administer the provision of a comprehensive package of AHCCCS covered acute care services to enrolled AHCCCS members.

“Home Health Services” In accordance with 9 A.A.C. 22, means the services provided by a home health agency that coordinates in-home intermittent services for curative and/or habilitative care. This includes home health aide services, licensed nurse services, medical supplies, equipment and appliances.

“Hospital” A health care institution licensed as a hospital, as defined in ARS § 36-2351.

“Independent Living Center (ILS)” Peer support and resources for transitioning youth with special needs.

“Inpatient” An individual who has been admitted at least overnight to a hospital for the purpose of receiving diagnostic, treatment, observation, or other CRS services.

“Interdisciplinary team” A team of health professionals from various disciplines and family members who collaborate in planning, delivering, and evaluating health care services.

“KidsCare” Arizona Children's Health Insurance Program, funded through Title XXI of the Social Security Act and state funds, also referred to as Title XXI. The KidsCare Program offers comprehensive medical preventive and treatment services and a full array of behavioral health care services statewide to eligible children under the age of 19.

“Local Health Department” Any district,, county, or city health department or any combination thereof.

“Medical Assistance” The Title XIX portion of the AHCCCS program, which also includes S.O.B.R.A.

“Medical Assistance Financial Screening Form” The DES document that identifies potential Title XIX eligibility.

“Medical Expense Deduction (MED)” A Medicaid eligibility category for a Title XIX Waiver member whose family income is more than 100% of the Federal Poverty Level (FPL) and has family medical expenses that reduce income to or below 40% of the FPL.

“Medical Foods” A metabolic formula or modified low protein foods that are produced or manufactured specifically for members with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder.

“Medical Home” An approach to providing comprehensive health care. A medical home is defined as care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

“Medical Information” All clinical records, medical reports, laboratory statements or reports, any file, film, record or report, or oral statement

relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects, and associates of communicable disease patients.

“Medical Management (MM)” An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).

“Medical Staff” All physicians and dentists employed by or under contract with CRS.

“Medically Necessary” As defined in A.A.C R9-22-101.B. means a medically necessary covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.

“Member” Is synonymous with the terms enrollee and insured. A member is any individual who is enrolled in the CRS Program.

“Member Abuse” Any intentional or reckless infliction of physical harm, injury caused by a negligent act or omission, unreasonable confinement, emotional or sexual abuse, or sexual assault to a CRS enrolled member.

“Methodology” The planned process, steps, activities or actions taken by a CRS Regional Contractor to achieve a goal or objective, or to progress toward a positive outcome.

“Minor” An individual who is:

1. Under the age of 18 years;
2. Incompetent as determined by a court of competent jurisdiction; or
3. Incapable of giving consent for medical services due to a limitation in the individual's cognitive function as determined by a physician.

“Monitoring” The process of observing, evaluating, analyzing and conducting follow-up activities.

“Multi-specialty” The use of more than one specialty physician or dentist in the treatment of a member.

“Notice of Action” Written notification to the member/representative of an

action that the CRS Regional Contractor has taken or intends to take.

“Notice of Appeal Resolution” Written notification to the member/representative and other parties of the decision made by the CRS Regional Contractor of an appeal.

“Notice of Decision” Written notification to the provider and other applicable parties of the decision made by the CRS Regional Contractor regarding a claims dispute.

“Notice of Denial” Written notice to the applicant/representative of the decision of the CRS Program to deny enrollment.

“Notice of Eligibility Decision” Written notification to the member/representative and other parties of the decision made by the CRS Regional Contractor of an eligibility decision.

“Notice of Hearing Request” Written notification to the CRS Regional Contractor that a member/representative or provider has requested an Administrative Hearing.

“Objective” A measurable step, generally in a series of progressive steps, to achieve a goal.

“Office of Civil Rights (OCR)” The office is part of HHS. Its HIPPA responsibilities include oversight of the privacy requirements

“Out of Network” Care provided by health care providers that are not a part of the CRS Regional Contractor provider network.

“Out of Network Referral” A provisionally covered benefit that requires prior authorization by CRS Regional Contractors for referrals to providers or facilities that are not in the network to satisfy unique health care needs of a CRS member.

“Outcome” A defined outcome that is the result of an intervention.

“Outcome Measurement” System used to track interventions and resulting outcomes.

“Outpatient Services” Health care services rendered to members who are not hospitalized.

“Outreach Clinic” A clinic designed to provide a limited specific set of services including evaluation, monitoring, and treatment in settings geographically closer to the family than a CRS Regional Clinic.

“Parent” A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

“Parent Action Council (PAC)” The regional council consisting of family members, parents, or legal guardians of children, who are, or have been, CRS members, or adults who are or were members. The Parent Action Council also includes professionals, advocacy groups, CRS Regional Contractor representatives, and ADHS/CRSA staff.

“Partial Transfer” Assignment of a member to two or more CRS Regional Contractors.

“Payment Responsibility” The portion of the cost of CRS services that a member or family has agreed to pay, according to a signed Payment Agreement.

“Pediatric Transition to Adulthood” All youth with special health care needs receive the services they need to make necessary transitions to all aspects of adult life, including adult health care, work and independence.

“Peer Review” The review and evaluation of a practitioner's professional actions related to care of CRS members, by a selected peer group.

“Performance Measurement” Defining a target goal and measuring the effectiveness of interventions on a projected outcome

“Physician” An individual currently licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Post Stabilization Services” Medically necessary services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition or to improve the member's condition.

“Practice Guidelines” The description of medical practices that assist clinicians in making appropriate decisions regarding health care.

“Primary Health Care” Routine health care provided to prevent disease, treat injury or maintain general health.

“Primary Care Provider (PCP)” An individual responsible for the primary management of the member's health care, as defined in 9 A.A.C. 22, Article 1. The PCP must meet the requirements of A.R.S. §36-2901.

The PCP must be an individual, not a group or association of persons, such as a clinic.

“Privacy” For purposes of the HIPAA Privacy Rule, an individual's interest in limiting who has access to personal health care information.

“Prior Authorization (PA)” The process by which a CRS Regional Contractor determines in advance whether a service is medically necessary... Prior authorization is not a guarantee of payment.

“Protected Health Information (PHI)” Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

“Privacy Notice” The CRS Regional Contractor must give notice describing practices regarding protected health information. The CRS members must obtain signed acknowledgements of receipt (also known as notice of privacy practices).

“Provider” A person or entity that subcontracts with a CRS Regional Contractor to provide CRS covered services directly to members.

“Provider Network” A person or entity who agrees to the terms specified in the contract with the CRS Regional Contractor.

“Provider Services Requisition (PSR)” A request from a health care provider to a CRS Regional Contractor for prior authorizing a service.

“Quality Improvement (QI)” The systematic application to assess and improve internal operations.

“Quality Management (QM)” The review of the quality of health care provided to CRS members.

“Qualified” An individual meets the conditions, criteria, or requirements for enrollment in the CRS Program.

“Quality of Care Concern” There is possibility that an action could negatively impact the member's health care status.

“Rehabilitation Act of 1973” First major legislative effort to secure an equal playing field for individuals with disabilities. This legislation provides a wide range of services for persons with physical and mental impairments. The Rehabilitation Services Administration (RSA) administers the Act. Two Sections have immense regulatory impact on accessible Web design. These are Section 504 and 508.

Section 504 of the Rehabilitation Act - Nondiscrimination Under Federal Grants and Programs.

“Reinsurance” A method of limiting the financial risk of providing services by purchasing insurance that becomes effective after set dollar amount has been reached.

“Reliability” The degree to which the measure is free from random error and the results are reproducible.

“Residence” The place where an individual lives.

“Resident” An individual who is living in Arizona and can provide proof of residency.

“Retrospective Review” The process of determining the medical necessity of a treatment/service post delivery of care.

“Sanction” Reprimand that for breaking a law or rule resulting in financial penalties.

“School” Any public or private institution offering instruction to students of any age.

“Scope of Service” The medical services covered under the CRS Program.

"S.O.B.R.A." The Sixth Omnibus Reconciliation Act, 1986 Section 9401, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a) (10)(A)ii(IX), July 1, 1988. This program provides Medical Assistance to eligible pregnant women as soon as possible following verification of pregnancy, and provides Medical Assistance to as many eligible children born on or after October 1, 1988, as is possible.

“Special Health Care Needs” Serious congenital or chronic physical, developmental, or behavioral conditions that require medically necessary health and related services of a type or amount beyond that required by children generally. All CRS members are considered to be members with special health care needs.

“Specialty Physician” A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.

“Social Security Administration (SSA)” The Federal agency that administers

SSI, SSDI, and related programs.

“Supplemental Security Income (SSI)” The Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

“State, the” The State of Arizona.

“State Parent Action Council (SPAC)” The state council consisting of family members, parents, or legal guardians of a child who is, or has been, a CRS member, or adults who are or were members. The SPAC includes professionals, advocacy groups, Regional Contractor representatives, and CRSA staff.

“Telehealth” The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education, and/or health care/medical learning (member not present).

“Telemedicine” The delivery of diagnostic, consultation and treatment services that occur in the physical presence of the member on a real time basis through interactive audio, video and data communications, as well as the transfer of medical data on a store and forward basis for diagnostic or treatment consultations.

“Termination Date” The date that a member is no longer eligible for services.

“Timely Appointment” An appointment timeframe that, if not met, may adversely affect the health of an enrolled member.

“Title V” The federal statutes governing the Maternal and Child Health Program, which is a public health service of the U.S. Department of Health and Human Services.

“Title XIX” The Federal Medicaid Program, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services to help those families and individuals become or remain independent and able to care for themselves.

“Title XXI” The State Children's Health Insurance Program (SCHIP), Title

XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage. In Arizona, the SCHIP program is known as KidsCare.

“Tracking of Disclosures” The HIPAA Privacy Rule gives individuals the right to request an accounting of disclosures of protected health information over the previous six years.

“Total Transfer” The assignment of a member to a different CRS Regional Contractor.

“Treatment Plan” A written plan of services and therapeutic interventions based on a comprehensive assessment of a member's developmental and health status, strengths, and needs that are designed and periodically updated by the interdisciplinary team.

“Trending” The method of estimating needs and costs of health services by reviewing past trends in cost and utilization of these services. Trending also means analysis of data to identify potential issues.

“Utilization Management/Review” The CRSA and the CRS Regional Contractor's process to evaluate appropriateness, efficacy and efficiency of medically necessary services.

“Youth” An individual over the age of 14 years but less than 21 years of age.

10.200 Introduction to the CRS Program

The following section provides an overview of CRS Program mission, goals, objectives, and general information about the organization and operation of the CRS Program. This section also contains information about services, providers, contractors, and the role of other state and federal agencies in CRS funding and oversight.

10.201 Mission, Goals and Objectives of the CRS Program

Mission

The mission of Arizona Children's Rehabilitative Services (CRS) is to improve the quality of life for children by providing family-centered medical treatment, rehabilitation, and related support services to enrolled individuals who have certain medical, handicapping, or potentially handicapping conditions.

Goal

The goal of the CRS Program is to provide quality care through early detection, prevention, comprehensive medical treatment, and rehabilitation to enrolled individuals with handicapping or potentially handicapping conditions.

Objective

The objective of CRS is to assure the highest quality comprehensive care for the functional improvement of medically qualified individuals through a family-centered, multi-specialty interdisciplinary team approach in a cost effective managed care setting.

10.202 Program Description and Organization

Program Description

CRS serves individuals under 21 years of age residing in Arizona, who meet the criteria established by CRSA. A combination of funding is received from state and federal sources. CRSA collects federal funding from the Arizona Health Care Cost Containment System (AHCCCS) Administration for Title XIX categorically eligible AHCCCS members and for Title XXI eligible members who are enrolled in the State Children's Health Insurance Program known as KidsCare. CRSA also receives funding through the Title V Maternal and Child Health Block Grant for Title V eligible persons.

CRS provides for medical treatment, rehabilitation, and related support services to individuals who have certain medical, handicapping, or potentially handicapping conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities. CRS provides these services through regional service contracts, where the approach to service delivery is family-centered, coordinated, culturally effective, and considers the unique needs of eligible persons. CRS is not a primary care provider. Each individual is expected to have a primary care provider from which to receive primary health care. The CRS clinic may provide a list of resources to individuals or families who do not have a primary care provider.

Program Organization

The Bureau for Maternal and Child Health is responsible for CRS at the federal level. This bureau is in the Public Health Service of the U.S. Department of Health and Human Services (PHS/DHHS), which oversees the Arizona Department of Health Services (ADHS). ADHS is responsible for the administration of the CRS Program as stated in Article 3, A.R.S. § 36-261, 262. ADHS coordinates, as applicable, with other State agencies to fulfill this requirement.

At the State level, CRSA operates within the Office for Children with Special Health Care Needs (OCSHCN), within Public Health Prevention Services within the ADHS. ADHS is responsible for employing a CRSA Medical Director and an OCSHCN Administrator for CRSA who shall have duties and titles as fixed by the ADHS Director.

CRSA is responsible for: monitoring and evaluating services provided by private contractors; keeping statistical data on the CRS population; providing support and consultant services; and ensuring overall program management and planning.

CRSA solicits contracts from qualified offers to provide CRS services in specific geographic regions of Arizona. These CRS Regional Contractors are responsible for the administration and delivery of CRS services for their own contracted region. CRS Regional Contractors develop and maintain a provider network of specialty physicians, personnel, and facilities to meet the CRS minimum requirements. CRS Regional Contractors may determine the appropriate reimbursement methods and amounts for their contracted provider network. CRSA oversees the performance of the CRS Regional Contractors. The CRS Regional Contractors are subject to contractual requirements, and follow policies and procedures, administrative rules, and laws.

10.203 Governing Statutes and Regulations

Federal

Title V, Part 2, of the Social Security Act (the Act) contains the general provisions setting up the powers and functions of the Social Security Administration, which may provide Title V federal funds to CRS. Part 2 makes provision for the appropriation and allocation of certain sums of money to the various states.

The Act requires that each state shall submit a plan for services for CRS individuals which will provide for financial participation by the State; administration of the plan by a state agency or supervision of the plan by a state agency; and appropriate methods of administration and reports. The Secretary of the Department of Health and Human Services must approve a state plan before federal subsidies can be provided to fund the CRS Program.

Funding will be denied should the Secretary of Health and Human Services find that the state operation of the CRS Program does not comply with the rules and regulations set down by the Social Security Administration.

Title XIX of the Act establishes the Medicaid program, which is a national health care program providing Medical Assistance to families and to aged, blind and disabled individuals whose income and resources are insufficient to meet

the cost of necessary medical services. The program is administered by the Centers for Medicare & Medicaid Services (CMS) of the federal Department of Health and Human Services (DHHS). Medicaid is a state/federal partnership under which the federal government establishes basic program rules. Each state must submit a State Plan describing how it will administer the Medicaid program within the confines of federal rules governing the program.

In Arizona, the Medicaid program is known as the Arizona Health Care Cost Containment System (AHCCCS). Federal Medicaid funding is available for all Medicaid-covered services rendered to enrolled CRS members who are federally eligible and enrolled in AHCCCS, in accordance with Arizona's Medicaid State Plan. Many children who are CRS members are concurrently enrolled in AHCCCS. The AHCCCS Administration also oversees the delivery of health care services funded by Title XXI, the State Children's Health Insurance Program. In Arizona, this program is known as KidsCare. Children who are medically qualified for CRS may also be enrolled in KidsCare. The CRS Administration works closely with the AHCCCS Administration to ensure CRS service delivery requirements are consistent with Medicaid and KidsCare requirements.

State

In accordance with the provisions of the Social Security Act, administration of the CRS Program in Arizona has been assigned by the Legislature to the ADHS.

Enabling legislation for CRS is found in Article 3, A.R.S. §§ 36-261 and 36-262. Enabling legislation for the care, treatment and reimbursement to the Department for individuals with sickle cell anemia is set forth in Article 13, A.R.S. §§36-797.43 and .44, respectively.

The adopted Rules for CRS are set forth in A.A.C., Title 9, Chapter 7, Articles 1 through 7.

10.204 Program Qualification Overview

Any individual may be referred to CRS. To be considered for the CRS program the applicant must:

1. Have a CRS medical condition;
2. Meet the age requirement;
3. Meet residency requirements in the state of Arizona; and
4. Provide documentation of legal residency in the United States.

Once these requirements are met, the amount of the member's payment responsibility is determined, based on the family's income and resources. Refer to Section 20.000 for enrollment requirements.

To be enrolled in the program, a member of the CRS professional staff shall evaluate the individual in a CRS pediatric screening clinic or specialty clinic. The physician or designee determines/verifies if the individual has a handicapping or potentially handicapping condition that qualifies for treatment in the CRS program.

10.205 Program Services

CRS Program services are set forth in A.A.C., Title 9, Chapter 7, Article 5, Section 501. Specific policies relative to CRS services are presented in Chapter 40.000 of this manual.

10.206 CRS Providers

The licensure and certification requirements for CRS providers are as follows:

1. Physicians and dentists must be licensed in the State of Arizona.
2. Nurses must be licensed in the State of Arizona.
3. Social Workers must be licensed in the State of Arizona.
4. Audiologists must maintain a current Arizona Audiologist license.
 - A. If non-certified or clinical fellowship year (CFY) personnel are utilized, they must be under the direct (onsite) supervision of an Arizona licensed audiologist.
2. Speech-Language Pathologists must maintain a current Arizona Speech-Language Pathologist license.
3. Orthotists and prosthetists must be certified by the American Board for Certification in Orthotics and Prosthetics.
4. Hearing aid dispensers must be licensed in the State of Arizona.
5. Pharmacists must be licensed in the State of Arizona.
6. Psychologists must be licensed by the State of Arizona Board of Psychologist Examiners.
7. Physical and occupational therapists must be licensed issued by the Arizona Board of Physical Therapy and the Arizona Board of Occupational Therapy, respectively.
8. Other Ancillary personnel must be licensed or certified if required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards.

Any individually contracted specialist such as a physician, dentist, psychologist, etc. who provides services to individuals enrolled in federally funded programs must be an AHCCCS registered provider in addition to their licensing requirements.

Facilities providing CRS services shall be licensed by the ADHS and Medicare certified by CMS, and/or accredited by the JCAHO, Accreditation Association for Ambulatory Health Care (AAAHC), or other nationally recognized accrediting body within two (2) years of licensure.

Primary and secondary level hospital services are provided by all CRS contract hospitals. Tertiary level hospital services are provided by Central and Southern facilities. Tertiary care is defined as cardiac or other medical/surgical services, which may require pediatric intensive care.

10.207 Communication of Changes In Program or Provider Network

Changes in program requirements for providing services, maintaining and reporting data, and complying with contractual agreements must be communicated by CRSA to the CRS Regional Contractors with sufficient time to accommodate the change, but no less than thirty (30) calendar days prior to the date the change is to go into effect unless required by law to be enacted sooner. Notification of the change must be in writing and the expected date of compliance must be included.

Any change in a CRS Regional Contractor's ability to comply with contractual requirements, including provider network changes, must be communicated to CRSA in writing together with the plan for accommodation of members who may be deprived of services, within one (1) business day of the inability to comply being identified in accordance with Chapter 80.600.

CRS Regional Contractors must give written notice about the termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each recipient who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)]. This notice must be provided to CRSA within one (1) business day.

CRS Regional Contractors must notify providers and recipients in writing thirty (30) calendar days prior to the effective date of a program change or any other change in the network, excluding a provider leaving the network. The notification letter must be submitted to CRSA forty five (45) calendar days prior to the effective date of the change for review and approval. [42 CFR 438.10(f)(4)].

10.208 CRS Program Funding

Federal Participation in the CRS Program

Under Title V of the Social Security Act, Congress may annually appropriate funds for states' programs for children with special needs. The federal law requires that out of this appropriation, the Secretary of the Department of Health and Human Services must allocate by statutory formula based on member of low income children and other factors a fixed amount to each state. A minimum of thirty percent mix allocation must be used for children with special health care needs. The State, in accepting these federal funds, agrees to conform with the

details of the State Plan for the provision of CRS authorized services. The State Plan is approved by the Secretary of Health and Human Services (HHS), to conform with the federal regulations applicable to state plans. As a condition of accepting federal funds, CRSA agrees to conform to all applicable federal regulations. The Secretary may also grant portions of the federal funds to individual special projects for the provision of specialized services to children.

Under Title XIX of the Act, federal funding is available for Medicaid-covered services provided to Title XIX categorically eligible individuals in the form of Federal Financial Participation (FFP). Each state has an established Federal Medical Assistance Percentage (FMAP) amount that is paid by DHHS for most Medicaid program expenditures, although that amount may be higher for certain types of expenditures.

In the State of Arizona, the AHCCCS Administration (AHCCCSA) has been designated as the single State agency to receive and distribute Title XIX and Title XXI funds. ADHS has an Interagency Service Agreement (ISA) with the AHCCCSA regarding the CRS program's use of Title XIX funds for the treatment of CRS conditions. To receive federal reimbursement for CRS services, CRSA shall submit financial reports and encounter data for the provision of CRS authorized services to AHCCCS no later than 30 days following each reporting period, as stipulated in the ISA between the AHCCCS Administration and ADHS. AHCCCS claims FFP from CMS and is required under the terms of its ISA with CRSA to pass through federal monies to CRS.

State Participation in the CRS Program

The State must participate in the financing of CRS according to the Social Security Act, Title V, Part 2, § 513.

The amount of State money available for CRS is determined annually through the Appropriations Act. CRSA receives AHCCCS funds and non-AHCCCS funds as two separate appropriations for program support. CRS receives State dollars for the "state match" needed in order to claim FFP.

Family Participation in the CRS Program

Individuals/families shall participate in a financial interview with a CRS Regional Contractor's staff member and/or onsite representative of the Department of Economic Security (DES) to determine the individual/family's payment responsibility. The payment responsibility is determined by comparing the family adjusted gross income to the current Federal Poverty Level limit amounts for income and family size.

Members who do not have a payment responsibility include the following:

1. Wards of the State or of the Court;

2. DES/Comprehensive Medical and Dental Program (CMDP) foster children;
3. DES adoption subsidy children; or
4. Children who are Title XIX or Title XXI eligible.

See Payment Responsibility Section, 20.500 and A.A.C. R9-7-207.

10.209 Statewide CRS Medical Directors'/Administrators' Meetings

Meetings of the CRSA Medical Director and CRS Administration along with CRS Regional Contractors' Medical Directors and Administrators provide an ongoing mechanism for the development and review of CRS policies and procedures, as well as the discussion and resolution of other contractual, programmatic, or operational issues regarding the CRS program. The meetings offer a forum for CRS Regional Medical Directors and Administrators to provide guidance and advice to CRSA Program Management and to review and comment on issues having statewide impact on regional program operations. Each Region has an opportunity to review and provide input to proposed policies and procedures before they are approved and implemented.

Meetings

The CRS Regional Medical Directors and Administrators shall meet with CRSA representatives no less than four times per year. Additional meetings may be requested by any member of the team to address major CRS Program issues having a significant impact on the delivery of care and/or regional program operations. The Administrators' Meeting includes CRSA Administration, CRS Regional Contractor Administrators, and parent representation from the Parent Action Council (PAC). The Medical Directors'/Administrators' Meeting includes CRSA Administrator, CRSA Medical Director, CRS Regional Contractor Medical Directors, Regional Contractor Administrators, and parent representation from the (PAC).

10.300 Interagency Coordination

It is the policy of the CRS Program to coordinate with other State and Federal agencies in the provision of services for CRS members.

10.301 AHCCCS Administration and AHCCCS Health Plans

CRS members may be concurrently enrolled in an AHCCCS acute care health plan or with an ALTCS Program Contractor, or a KidsCare Program (administered by AHCCCS) to receive acute or long-term care health services. CRS Regional Contractors' staff coordinates care for members with staff of AHCCCS plans and program contractors and other insurers as needed and appropriate.

The AHCCCS Administration is responsible for determining member eligibility for Title XXI and for the ALTCS program. CRS is subject to AHCCCS rules and policies as they apply to CRS members enrolled in Title XXI programs.

10.302 Arizona Department of Economic Security (DES)

The Arizona Department of Economic Security is responsible for determining member financial eligibility to federally funded programs such as Title XIX. CRS is subject to AHCCCS rules and policies as they apply to CRS members enrolled in Title XIX programs.

The CRS Program coordinates treatment and service delivery with other agencies such as Arizona Early Intervention Program (AzEIP) and the Department of Developmental Disabilities (DDD) for identification, diagnosis, and treatment.

10.303 Department of Education

“State Educational Agency (SEA)” is an organization governing every school district in each state and is autonomous with individual school districts, known as “Local Education Agency (LEA)”. The Local Education Agency is a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or secondary schools. The Local Education Agency includes:

- An educational service agency,
- Any other public institution or agency having administrative control and direction of a public elementary or secondary school, including a public charter school that is established as an LEA under State law; and
- An elementary or secondary school funded by the Bureau of Indian Affairs, not subject to the jurisdiction of any SEA other than the Bureau of Indian Affairs, but only to the extent that the inclusion makes the school eligible for programs for which specific eligibility is not provided to the school in another provision of law and the school does not have a student population that is smaller than the student population of the LEA receiving assistance under this Act with the smallest student population.

10.304 Indian Health Services, Fee for Service

CRS Regional Contractors may coordinate with the Indian Health Service (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Regional Contractors' staff coordinates care for

members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to IHS fee for service rules and policies as they apply to CRS members.

10.305 IHS AHCCCS

CRS Regional Contractors may coordinate with Indian Health Services (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Regional Contractors' staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to AHCCCS rules and policies as they apply to CRS members.

10.306 IHS Tribal Health Services

CRS Regional Contractors may coordinate with Indian Health Services (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Regional Contractors' staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to identified tribal entity rules and policies as they apply to CRS members.

Identification of "Potential Healthcare Needs" means ADHS, BH, RBHA's, Oral Health, OWCH (school readiness board), newborn screening, chronic disease, WIC, Immunization, OCSHCN, Sickle Cell, School Nurses, Asthma Coalition, Federally mandated programs, and Governors Council (Head, Spine, DD).